DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 99-011

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
June ~~15~~ 16, 1999

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 99 $ 312
b. FFY 00 $ 342

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 - A pages 9a, 10a

~~Appendix B page 6~~
Attachment 4.19-B, Appendix A, pages 1, 2, 3.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 - A pages 9a - 10a

Appendix B page 6

10. SUBJECT OF AMENDMENT:
Revise final settlement for outpatient hospital services and provider based Rural Health Clinic services. Provides for rate adjustment to recognize the property tax when a hospital changes from non profit to proprietary.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT 21
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary J. Stangler

14. TITLE:
Director

15. DATE SUBMITTED:
June 29, 1999

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
06/30/99

18. DATE APPROVED:
AUG 28 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
06/16/99

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE: Acting
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Martin
Vadner
Waite
CO

SPA CONTROL
Date Submitted 06/29/99
Date Received 06/30/99

FORM HCFA-179 (07-92)

Instructions on Back

2. The state agency shall review audited Medicaid-Medicare cost reports for each hospitals fiscal year in accordance with Appendix B.

E. Adjustments to Rates

The prospectively determined individual hospital's reimbursement rate may be adjusted only under the following circumstances:

1. When information contained in the cost report is found to be intentionally misrepresented. Such adjustment shall be made retroactive to the date of the original rate. Such adjustment shall not preclude the Medicaid agency from imposing any sanctions authorized by any statute or regulation;

2. When rate reconsideration is granted in accordance with subsection V.F.;

3. When the Medicare per-diem rate is changed by the servicing fiscal intermediary based on a new audit finding for the base year. This adjustment may be applied and effective no earlier than the first day of the month following notification by the Division of Medical Services; and

4. When hospital documents to the Division of Medical Services a change in its status from nonprofit to proprietary, or from proprietary to nonprofit, its direct Medicaid payments for the State Fiscal Year will be adjusted to take into account any change in its Medicaid inpatient allowable costs due to the change in its property taxes. The Medicaid share of the change in property taxes will be calculated for the State Fiscal Year in which the change is reported by multiplying the increase or decrease in property taxes applicable to the current State Fiscal Year by the ratio of allowable Medicaid inpatient hospital costs to total costs of the facility. (For example: if the property taxes are assessed starting January 1 for the calendar year, then one-half of the calendar year property taxes will be used to calculated the additional inpatient direct Medicaid payments for the period of January1 to June 30.

(c) When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

(a) The use of Medicare standards and reimbursement principles;

(b) The method for determining the trend factor;

(c) The use of all-inclusive prospective reimbursement rates; and

(d) Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the change in its property taxes see paragraph (5)(E)4.

4. As a condition of review the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review. Such review will be made at the discretion of the State Medicaid Agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally accepted accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified of the Agency's decision in writing within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty the sixty (60)-day period, the request shall be deemed denied.

G. Sanctions

Sanctions may be imposed against a provider in accordance with applicable state and federal regulations.

*Substitute per letter dated 07/9/01 **

I. Outpatient hospital settlements, Provider-Based Rural Health Clinic (PBRHC) settlements or Provider-Based Federally Qualified Health Centers (PBFQHC) settlements will be calculated after the Division receives the Medicare/Medicaid cost report with a Notice of Provider Reimbursement from the hospital Fiscal Intermediary.

A. The Division of Medical Services shall adjust the hospital's outpatient Medicaid payments, PBRHC/PBFQHC Medicaid payments (except for those hospitals that qualify under subsection (1)(B), whose payments will be based on the percent of cost in (1)(A)1., or 2. for:

1. Services prior to January 5, 1994, the lower of eighty percent (80%) of the outpatient share of the costs from subsection (1)(D), or eighty percent (80%) of the outpatient charges from paragraph (1)(C)1.,;

2. Services after January 4, 1994, the lower of ninety percent (90%) of the outpatient share of the cost from subsection (1)(D), or ninety percent (90%) of the outpatient charge from paragraph (1)(C)1.;

3. PBRHC and PBRQHC shall be reimbursed 100% of the lower of its share of the cost in subsection (1)(D) or its charges in paragraph (1)(C)2.

B. A facility that meets the Medicare criteria of nominal charge provider for the fiscal period shall have its net cost reimbursement based on its cost in subsection (1)(A)1., or 2.

C. The Medicaid charges used to determine the cost, and the payments used to determine the settlement will be:

1. For outpatient services the charges and payments extracted from the Medicaid outpatient claims history for reimbursable services paid on a percentage basis under 13 CSR 70-15010.

2. For provider based PBRHC and PBFQHC the charges and payments will be services billed under 13 CSR 70-94.020.

D. The Medicaid hospital's outpatient, PBRHC or PBFQHC cost will be determined by multiplying the overall outpatient cost-to-charge ratio, determined in accordance with paragraph (1)(D)1., by the Medicaid charges from paragraph (1)(C)1. To this product will be added the Medicaid outpatient share of GME. The GME will be determined using the methodology on worksheet E-3 part IV from the Medicare/Medicaid cost report (HCFA 2552-92) by substituting Medicaid data in place of Medicare data:

1. The overall outpatient cost-to-charge ratio will be determined by multiplying the reported total outpatient charges for each ancillary cost center excluding PBRHC or PBFQHC on the supplemental worksheet C column 1 (HCFA 2552-83) or substitute schedule by the appropriate cost-to-charge ratio from worksheet C (2552-92) column 7 part I of the fiscal intermediary's audited Medicare/Medicaid cost report to determine the outpatient cost for each cost center that is reimbursed on a percentage of charge basis by Medicaid under 13 CSR 70-15.010. Total the outpatient costs from each cost center and total the outpatient charges from each cost center. Divide the total outpatient costs by the total outpatient charges to arrive at the overall outpatient cost-to-charge ratio.

E. The Medicaid outpatient final settlements will determine either an overpayment or an underpayment for the hospital's outpatient services and PBRHC or PBFQHC:

1. The outpatient Medicaid cost determined in section (1)(D) is multiplied by the percent of cost allowed in paragraph (1)(A)1., or 2., to determine the reimbursable cost for outpatient services. (If a cost report covers both periods the outpatient Medicaid charges will be split to determine the reimbursable cost for each time period.) From this cost subtract the outpatient payments made on a percentage of charge basis under 13 CSR 70-15.010 for the time period. (Medicaid payments include the actual payment by Medicaid, third party payments, coinsurance and deductibles.) The difference is either an overpayment (negative amount) due from the provider or an underpayment (positive amount) due to the provider; and

A. For PBRCH or PBFQHC services multiplying the PBRHC or PBFQHC charges from paragraph (1)(C)2., by the cost center's cost-to-charge ratio to determine PBRHC or PBFQHC cost. From this cost, the

PBRHC or PBFQHC payments associated with charges from paragraph (1)(C)2., are subtracted. The difference is either an overpayment (negative amount) due to the provider or an underpayment (positive amount) due to the provider.

II Reopened cost reports received after the Division has completed a final settlement will be calculated in the same manner as the original settlement. If the amended cost report changes, the previous settlement by less than one hundred dollars ($100), the cost report will not be reopened.